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	HAL026048	A. BUILDING: _____ B. WING _____	R 04/16/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and follow-up survey on 04/14/21, 04/15/21, and 04/16/21.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure that water temperatures were maintained at 100° to 116° degrees Fahrenheit (F) for 1 of 3 fixtures in the men's common bathroom with temperatures of 84.4° degrees F to 86.2° degrees F. The findings are: Observation of men's bathroom on 04/14/21 at 10:07am revealed: -The water temperature at the tub was 85.4°F. -There had not been a precaution placed at the tub informing the residents there was no hot water. Interview with a resident on 04/14/21 at 12:31pm revealed: -He had used the tub to take baths and the hot	D 113		

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water was cold.
-The water took "a while" to warm up and the water did not "get hot".
-Everyone knew the tub did not have hot water.
-The water had been cold for about "a week or two."

Observation of men's bathroom on 04/15/21 at 8:48am revealed the water temperature at the tub was 86.0°F.

Interview with a second resident on 04/15/21 at 12:33pm revealed:
-He did not use the tub to bath because it did not have hot water.
-"I'm not taking a cold bath."
-He had told staff the tub did not have any hot water.
-The tub had been without hot water for about a week.
-He told staff the water did not get hot on last week.

Interview with a third resident on 04/15/21 at 12:35pm revealed:
-The tub did not have hot water.
-If the water ran for 30 minutes to an hour it did not warm up.

Observation of the men's bathroom on 04/16/21 at 9:01am revealed the water temperature recheck for the tub was 83.4°F.

Interview with a personal care aide (PCA) on 04/14/21 at 10:10am revealed:
-She did not know how long the hot water was running cold.
-The residents had not told her the water was not hot.
-She did not use the men's bathroom to assist

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with bathing because it was easier using the shower.

Observation of water thermometers being calibrated on 04/15/21 from 11:39am-11:50am revealed:
-The Maintenance Supervisor and Surveyor's water thermometers were placed in a cup of ice water.
-The Maintenance Supervisor's thermometer temperatures was 33.4°F.
-The Surveyor's thermometer temperature was 32.0°F.

Observations of re-check of water temperatures with the Maintenance Supervisor on 04/15/21 at 11:50am revealed:
-There had not been a precaution sign placed at the tub informing residents there was no hot water.
-The Maintenance Supervisor's water temperature at the tub was 86.2°F
-The Surveyor's water temperature at the tub was 86.2°F.

Interview with the Maintenance Supervisor on 04/15/21 at 11:42am revealed:
-He completed hot water temperature checks every other day.
-He had not completed a hot water check log.
-He was not required to log the hot water temperatures.
-He had adjusted the hot water heater the afternoon of 04/14/21.
-He rechecked the water temperature for the tub and did not record the water temperature.
-If there was an issue with the hot water, he reported the problem to the Administrator or the Owner

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D 113	Continued From page 3 Interview with the Administrator on 04/15/21 at 11:12pm revealed: -The Maintenance Supervisor was the person responsible for checking the hot water temperature. -He was not sure how often the hot water temperature should be checked. -He did not know if the Maintenance Supervisor kept a hot water temperature log. -He did not complete facility walk throughs with the Maintenance Supervisor, he only gave directives. Interview with the Owner on 04/15/21 at 9:07am revealed: -There was not a "special person" who completed hot water temperature checks, but it had been mostly completed by the Maintenance Supervisor. -The Maintenance Supervisor was not required to keep a hot water temperature check log. -A water temperature log was "just not kept." -The Maintenance Supervisor had turned up the water temperature on the hot water heater on yesterday afternoon, 04/14/21. -She did not know if the Maintenance Supervisor had rechecked the hot water temperature in the men's bathroom. -The plumber had been called and she would ask the plumber to check the hot water temperature for the men's tub. -She thought the required hot water temperature were 105°F to 110°F. -It was the Maintenance Supervisor's responsibility to monitor the hot water temperature. -She and the Administrator supervised the Maintenance Supervisor..	D 113		

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D 139	Continued From page 4	D 139		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 3 sampled staff (Staff C) who had not lived in the state for five years, had completed a national criminal background check upon hire. The findings are: Review of Staff C, Personal Care Aide's (PCA) personnel record revealed: -There was an application for employment from Staff C dated 12/18/20. -Staff C's employment history documented Staff C worked in another state from January 2017 through January 2020. -Staff C's address listed on the employment history was for another state. -There was no date of hire documented in Staff C's personnel record. -There was documentation that a NC statewide criminal records search was completed on 01/13/21. -There was no documentation a national criminal background check had been completed. Interview with Staff C on 04/14/21 at 10:22am revealed: -She had been employed at the facility since December 2020. -She was hired as a personal care aide.	D 139		

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D 139	Continued From page 5 -This was her first job as a PCA. Interview with Staff C on 04/16/21 at 12:20pm revealed: -She relocated to North Carolina from another state. -She had been in North Carolina since November 2020. -She had not been asked to have fingerprinting done since employment at the facility. Observations of Staff C at intervals during the survey on 04/14/21 through 04/16/21 revealed: -She provided care to residents in resident rooms on multiple days. -She conducted a card game activity in the dining room with multiple residents on 04/16/21. Interview with the Resident Care Coordinator (RCC) on 04/16/21 at 10:45am revealed: -Staff C was hired on 12/21/20. -The Administrator was responsible for completing criminal background checks for staff upon hire. Interview with the Administrator on 04/16/21 at 11:30am revealed: -He had not completed a national criminal background check for Staff C. -He was not aware a national criminal background check was needed for Staff C. -He could not recall how long Staff C had been living in North Carolina.	D 139		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the	D 315		

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residents' active involvement with each other, their families, and the community.
(b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.

This Rule is not met as evidenced by:
Based on record reviews and observations the facility failed to ensure residents were offered activities designed to promote the residents' active involvement.

The findings are:

Record review of the April 2021 activities calendar posted in the hallway on 04/15/21 at 10:44am revealed:
-On 04/11/21 from 11:00am-1:00pm Church service was scheduled.
-On 04/11/21 from 4:00pm-5:00pm word search was scheduled.
-On 04/12/21 from 10:00am-11:00am current events was scheduled.
-On 04/12/21 from 4:00pm-5:00pm Residents' choice was scheduled.
-On 04/13/21 from 10:00am-11:00am dominos was scheduled.
-On 04/13/21 from 4:00pm-5:00pm find the differences was scheduled.
-On 04/14/21 from 10:00am-11:00am arts and crafts was scheduled.
-On 04/14/21 from 4:00pm-5:00pm checkers was scheduled.
-On 04/15/21 from 10:00am-11:00am a board game was scheduled.
-On 04/15/21 from 4:00pm-5:00pm a card games

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was scheduled.
-On 04/16/21 from 10:00am-11:00am a memory match game was scheduled.
-On 04/16/21 from 4:00pm-5:00pm a Residents' choice was scheduled.
-On 04/17/21 from 10:00am-11:00am Guest Speaker was scheduled.
-On 04/17/21 from 4:00pm-5:00pm manicures was scheduled.
-There was 14 hours of activities scheduled for the week of April 11-17, 2021.

Observation on 04/14/21 at 10:26am revealed:
-There was not a scheduled activity held within the facility.
-No activities had been offered to the residents.
-There were 4 residents seated in the hallway.
-There were 4 residents seated in the living room watching TV.

Observation on 04/14/21 at 4:15pm revealed:
-There was not a scheduled activity held within the facility.
-No activities had been offered to the residents.
-There were 4 residents seated in the hallway.
-There were 6 residents seated in the living room watching TV.

Observation on 04/15/21 at 10:09am revealed:
-There was not a scheduled activity held within the facility.
-No activities had been offered to the residents.
-There were 4 residents seated in the hallway.
-There were 2 residents seated in the living room watching TV.

Interview with a resident on 04/15/21 at 3:45pm revealed:
-There was not an activity held on today.
-She liked to play card games and board games,

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but activities had not been held in a long time.
-The church service stopped because of COVID-19.
-There was staff that conducted activities with the residents sometimes.

Interview with a second a resident on 04/15/21 at 3:38pm revealed:
-Activities were not held every day.
-The activities stopped because of COID-19.
-She liked to play bingo and board games.
-She did not know why activities were not held every day.
-The residents did not have church services on the front porch.

Observation of activity supplies on 04/15/21 at 11:24pm revealed the facility had supplies to conduct their scheduled activities.

Interview with the personal care aide (PCA) on 04/15/21 at 11:25pm revealed:
-The residents did not want to participate in activities.
-She had announced when activities was held.
-The activities schedule was not always followed.
-The activities were not always held because of other staff duties and assignments.
-She was not sure if church services had been held at the facility.
-The facility did not have an Activities Director.

Interview with the Owner on 04/15/21 at 9:07am revealed:
-The facility no longer had an Activities Director as of last summer 2020.
-Some residents had church services on the front porch by the volunteer.
-The staff were responsible for conducting activities with the residents.

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-She did not know when the last activities were held with the residents.
-She expected the staff to conduct activities daily.
Observation of the facility on 04/14/21 throughout the day revealed:
-There was an activities calendar posted on the wall of the facility in the main hallway.
-Residents sat along the halls, in their bedrooms or in the dayroom watching television much of the day.
-No activities were observed being conducted.
-There was no observation of staff offering group or individual activities to the residents.

Interview with a fourth Resident on 04/15/21 at 8:30am revealed:
-The activities calendar posted in the facility was "just for show".
-The facility did not offer activities except for on holidays.

Interview with a personal care aide (PCA) on 04/15/21 at 8:50am revealed:
-She conducted activities when there was time but did not usually go by the posted activities calendar.
-She offered a coloring activity to the residents
-Staff were too busy with other duties to offer activities in the mornings.
-Activities were offered from 3:00pm-4:00pm if staff was available.

Interview with a fifth Resident on 04/15/21 at 4:10pm revealed:
-She was playing "Memory" cards with the PCA.
-It was unusual for activities to be provided.
-Residents sat around and watched television.

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D 358	Continued From page 10	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 11 residents (#2 #3) observed during the medication passes including errors with an anti-inflammatory and pain medication (#2) and not having a dopamine agonist medication refilled and available for administration (#3); and for 3 of 4 residents sampled (#2,#3.#4) for record review including errors with medications to treat diabetes (#2), dietary supplements (#3), and not administering numerous doses of an anticonvulsant and an electrolyte medication (#4). The findings are: 1.The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 12:00 medication passes on 04/14/21 and 04/16/21. a. Review of Resident #2's current FL-2 dated 10/06/20 revealed:	D 358		

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-Diagnoses included dementia, diabetes, cardiac dysthymia, pacemaker, depression, hypertension and ecchymosis.
-There was an order for Diclofenac 1% gel 4gms to each knee three times a day. (Diclofenac is used to treat inflammation and pain.)

Observation of the 12:00am medication pass on 04/14/21 revealed:
-The medication aide/Resident Care Coordinator (MA/RCC) retrieved the appropriate medication, gloves and a tool used to measure the appropriate dose of the prescribed medication and carried the items to the bedside of Resident #2.
-She squeezed a line of the Diclofenac Sodium 1% gel onto the measuring tool to 4gms.
-She rubbed the 4gms of gel in her gloved hands and then proceeded to rub the gel onto both of Resident #2's knees at the same time, one hand on each knee.
-She was prompted to check the order for the correct dose.
-She went back to the resident room after checking the order and reapplied another 4 gms using the same process.

Review of Resident #2's April 2021 electronic medication administration record (eMAR) revealed:
-There was a computer entry for Diclofenac Sodium 1% gel 4gms to each knee three times a day and scheduled for 8:00am, 12:00pm and 8:00pm.
-There was documentation the Diclofenac Sodium 1% gel 4gms had been administered as ordered.

Interview with the medication aide/Resident Care Coordinator (MA/RCC) on 04/14/21 at 12:45pm

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revealed:
-She thought the order was for 4gms total.
-She always administered the Diclofenac 1% gel using 4gms measured and applied to both of Resident #2's knees in the same way.

Based on observation, interview and record review, it was determined Resident #2 was not interviewable.

Attempted interview with the primary care provider for Resident #2 on 04/16/21 at 8:40am was unsuccessful.

b. Review of Resident #3's current FL2 dated 04/07/2021 revealed:
-Diagnoses included dementia, insulin dependent diabetes mellitus, elevated cholesterol, HDV, urinary incontinence, osteoarthritis, obesity, peripheral neuropathy, gastroparesis, bipolar disorder, and hypothyroidism..
-There was an order for Pramipexole 0.25mg (a dopamine agonist used to treat Parkinson's disease) one tablet three times a day.

Observation of the 12:00pm medication pass on 04/14/21 revealed:
-Pramipexole 0.25mg was not administered to Resident #3.
-Resident #3 was able to hold her water cup and drink from it independantly with minimal tremors of the hands.

Review of Resident #3's April 2021 electronic medication administration record (eMAR) revealed:
-There was a computer entry for Pramipexole 0.25mg to be administered three times a day and was scheduled for 8:00am, 12:00pm and 8:00pm.
-There was documentation of administration as

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ordered through the 8:00am dose on 04/14/21.
-There was documentation the 12:00pm dose of Pramipexole 0.25mg was not administered on 04/14/21.
-There was an exception note for 04/14/21 at 3:10pm that which read "med not available".

Interview with the medication aide/Resident Care Coordinator (MA/RCC) at 12:25pm during the medication pass on 04/14/21 revealed:
-There was no Pramipexole 0.25mg tablets on the medication cart for Resident #3.
-The refill had not been picked up from the pharmacy.

Interview with the MA/RCC on 04/16/21 at 10:55am revealed:
-She and another MA were responsible for ensuring medications were refilled when there were 3-5 doses left.
-She sent a refill request for Resident #3's Pramipexole to the pharmacy on 04/14/21.
-There was no schedule for cart audits to be completed but she "tried to do it twice a month when she got the chance."
-Cart audits were not documented.
-The other MA looked at medications that needed to be refilled but she did not know when or how often.
-The Pramipexole refill should have been requested sooner so the refill would not have run out.
-Medications should be administered as prescribed by the physician.

Attempted interview with the primary care provider for Resident #2 on 04/16/21 at 8:40am was unsuccessful.

2. Review of Resident #4's current FL-2 dated

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D 358	Continued From page 14 12/14/20 revealed diagnoses included seizures, hydrocephalus since birth, and inappropriate secretion of antidiuretic hormone. a. Review of Resident #4's current FL-2 dated 12/14/20 revealed an order for Carbamazepine XR 400mg (an anti-convulsant medication used to prevent seizure activity.) to be administered twice a day Review of Resident #4's April 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Carbamazepine XR 400mg to be administered twice a day and was scheduled for 10:00am and 10:00pm. -There was documentation Carbamazepine XR 400mg was not administered at 10:00am on 04/01/21 through 04/02/21, 04/05/21, 04/09/21 and 04/13/21 through 04/16/21. -There was documentation Carbamazepine XR 400mg was not administered at 10:00pm on 04/01/21. -There were exception notes for Carbamazepine XR 400mg not being administered at 10:00am on 04/01/21 through 04/02/21, 04/05/21, 04/09/21 and 04/13/21 through 04/16/21 that read "out of facility". -There was no exception note for Carbamazepine XR 400mg not being administered at 10:pm on 04/01/21. Review of Resident #4's March 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Carbamazepine XR 400mg to be administered twice a day and was scheduled for 10:00am and 10:00pm. -There was documentation Carbamazepine XR 400mg was not administered at 10:00am on	D 358		

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03/01/21 through 03/03/21, 03/05/21, 03/08/21 through 03/10/21, 03/12/21, 03/16/21 through 03/17/21, 03/26/21, 03/29/21 and 03/31/21.
-There were exception notes for Carbamazepine XR 400mg not being administered at 10:00am on 03/01/21 through 03/03/21, 03/05/21, 03/08/21 through 03/10/21, 03/12/21, 03/16/21 through 03/17/21, 03/26/21, 03/29/21 and 03/31/21 that read "out of facility".

Review of Resident #4's February 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Carbamazepine XR 400mg to be administered twice a day and was scheduled for 10:00am and 10:00pm.
-There was documentation Carbamazepine XR 400mg was not administered at 10:00am on 02/16/21, 02/18/21, 02/23/21,02/25/21 and 02/26/21.
-There were exception notes for Carbamazepine XR 400mg not being administered at 10:00am on 02/16/21, 02/18/21, 02/23/21,02/25/21 and 02/26/21 that read "out of facility".

Interview with the medical assistant from the primary care provider's office (PCP) on 04/16/21 at 2:10pm revealed:
-She did not know why Carbamazepine XR was prescribed for Resident #4.
-She thought the medication was used to prevent blood clots and treat nerve pain.
-The facility had not notified them of any missed doses prior to 04/16/21.
-She was not made aware of how often Resident #4 missed doses of the Carbamazepine.

Interview with Resident #4 on 04/16/21 at 2:20pm revealed:
-Carbamazepine XR was prescribed to her to

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prevent seizures.
-She attended a day program outside the facility Monday through Friday.
-Medications were not sent with her to the day program for administration while she was there.
-She did not receive medications while at the day program.
-She could not say when she had last had a seizure but it had been a long time.

Interview with the medication aide/Resident Care Coordinator (MA/RCC) on 04/16/21 at 2:40pm revealed:
-Resident #4 attended a day program Monday through Friday.
-Medications were not sent with Resident #4 to be administered while participating in the day program.
-Resident #4 left the facility at different times and could receive the 10:00am dose of Carbamazepine XR if she was still at the facility at 9:00am.
-She had not notified the PCP of the missing doses of Carbamazepine XR.
-She did not know if the PCP was aware Resident #4 attended a day program and was not in the facility during administration time.

Interview with the Administrator on 04/16/21 at 11:40am revealed he expected medications to be administered as ordered.

Attempted interview with Resident #4's PCP 04/16/21 at 2:10pm were unsuccessful.

b. Review of Resident #4's current FL-2 dated 12/14/20 revealed an order for Sodium Chloride 1gm (an electrolyte used to treat the syndrome of inappropriate secretion of anti-diuretic hormone.) to be administered four times a day.

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D 358	Continued From page 17 Review of Resident #4's April 2021 electronic medication administration record (eMAR) revealed: -There was a computer entry for Sodium Chloride 1gm to be administered four times a day and was scheduled for 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was documentation Sodium Chloride 1 gm was not administered at 12:00pm on 04/01/21, 04/02/21, 04/05/21, 04/07/21 through 04/09/21 and 04/12/21 through 04/16/21. -There were exception notes for Sodium Chloride 1 gm not being administered at 12:00pm on 04/01/21, 04/02/21, 04/05/21, 04/07/21 through 04/09/21 and 04/12/21 through 04/16/21 that read "out of facility". Review of Resident #4's February 2021 electronic medication administration record (eMAR) revealed: -There was a computer entry for Sodium Chloride 1gm to be administered four times a day and was scheduled for 8:00am, 12:00pm,4:00pm and 8:00pm. -There was documentation Sodium Chloride 1gm was not administered at 12:00pm on 02/16/21,02/18/21and 02/23/21 through 02/26/21. -There were exception notes for Sodium Chloride 1gm not being administered at 12:00pm on 02/16/21,02/18/21,02/23/21 through 02/26/21 that read "out of facility". Interview with the medical assistant from Resident #4's primary care provider's office (PCP) on 04/16/21 at 2:10pm revealed: -She did not know why Sodium Chloride 1gm was prescribed for Resident #4. -The facility had not notified them of any missed doses prior to 04/16/21.	D 358		

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D 358	Continued From page 18 -She was not made aware of how often Resident #4 missed doses of the Sodium Chloride. Interview with Resident #4 on 04/16/21 at 2:20pm revealed: -She attended a day program outside the facility Monday through Friday. -Medications were not sent with her to the day program for administration while she was there. -She did not receive medications while at the day program. Interview with the medication aide/Resident Care Coordinator (MA/RCC) on 04/16/21 at 2:40pm revealed: -Resident #4 attended a day program Monday through Friday outside of the facility. -Medications were not sent with Resident #4 to be administered while participating in the day program. -Resident #4 was not in the facility for the 12:00pm dose of Sodium Chloride 1gm to be administered. -She had not notified the PCP of the missing doses of Sodium Chloride. -She did not know if the PCP was aware Resident #4 attended a day program and was not in the facility during the 12:00pm administration time. Interview with the Administrator on 04/16/21 at 11:40am revealed he expected medications to be administered as ordered. Attempted interview with Resident #4's PCP 04/16/21 at 2:10pm was unsuccessful. 2. Review of Resident #2's current FL2 dated 10/06/20 revealed: -Diagnoses included dementia, diabetes, cardiac dysthymia, pacemaker, depression, hypertension and ecchymosis.	D 358		

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D 358	Continued From page 19 -There was an order for Levemir 3 units at bedtime and Novolog 6 units three times a day with each meal. Review of Resident #2's pharmacy review dated 01/11/21 revealed Resident #2 was to take Levemir FlexTouch 3 units at bedtime and Novolog FlexTouch 6 units three times a day with each meal. Review of Resident #2's hospital discharge summary dated 03/28/21 revealed there was an order for Levemir FlexTouch 100 ml inject 8 units two times a day. Review of Resident #2's April 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Levemir flextouch100 ml inject 8 units scheduled at 8:00am and 8:00pm. -The Levemir was documented as withheld per doctors/nurses' order on 04/03/21 at 8:00am with fingerstick bllod sugar (FSBS) of 98. -The Levemir was documented as withheld per doctors/nurses' orders on 04/09/21 at 8:00am with a FSBS of 93 and at 8:00pm with a FSBS of 144. -The Levemir was documented as withheld per doctors/nurses' orders on 04/10/21 at 8:00am with a FSBS of 105. -The Levemir was documented as withheld per doctors/nurses' order on 04/12/21 at 8:00pm with a FSBS of 178. Interview with a medication aide (MA) on 04/15/21 at 3:27pm revealed: -He did not have any knowledge of Resident #2's insulin being withheld. -He did not know if the primary care physician (PCP) had been contacted.	D 358		

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D 358	Continued From page 20 -He asked information about Resident #2 be obtained from the RCC. Interview with the contracted Registered Nurse (RN) on 04/16/21 at 8:31am revealed: -Resident #2 had a diagnosis of Type 2 diabetes. -Resident #2 had been prescribed to take a scheduled insulin. -Resident #2 did not have FSBS parameters because there was not any concerns in managing her blood sugar. -The PCP had not given any orders to withhold Resident #2's insulin. -Resident #2's FSBS of 48 or lower was a concern and the PCP should be notified for guidance whether to administer insulin. -No one from the facility had contacted the PCP to informed them of Resident #2 FSBS being low. -The facility staff were expected to contact Resident #2 PCP for guidance if her FSBS level was low. -When insulin was withheld, the blood sugar level would become unregulated. -If the blood sugar level was unregulated it could fluctuate and cause complications like urinary tract infections and affect mental status. Interview with the Resident Care Coordinator (RCC) on 04/16/21 at 3:27pm revealed: -There was no documentation for Resident #2 where the PCP had been called to have her insulin withheld in April 2021. -She had informed the PCP on 04/09/21 visit that Resident #2's FSBS was sometimes low in the mornings. -The PCP did not give an order for parameters. -The RCC would contact the PCP if Resident #2's FSBS was below 80. -There was not an internal written policy on parameters.	D 358		

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-The MAs were to contact the PCP if there was a concern with a resident's insulin and/or blood sugar and to get guidance on administering the insulin.
-The MAs were to document in the residents' charting notes of all communications with the PCP.
-If the MAs did not document in the residents' charting notes it would be a concern why the insulin had been withheld and had it been documented correctly on the MARs.
-The RCC had noticed on Resident #2's April's 2021 eMARs the insulin had been withheld which was why she informed the PCP on 04/09/21.
-The RCC did not review the MARs because she had enough work to do.

Interview with the Owner on 04/16/21 at 11:45am revealed:
-The MAs were to document when they could not contact the PCP.
-The MAs were to get a confirmed verbal order in writing when medications were withheld.
-The MAs had access to the residents' charting notes.
-The MAs were supervised by the RCC.

Based on observations, interviews and record reviews, it was determined that Resident #2 was not interviewable.

3. Review of Resident #3's current FL-2 dated 04/07/21 revealed diagnoses included dementia, insulin dependent diabetes mellitus, elevated cholesterol, urinary incontinence, osteoarthritis, obesity, peripheral neuropathy, gastroparesis, bipolar disorder, and hypothyroidism.

a. Review of Resident #3's physician's orders dated 12/12/20 revealed an order for Mag 64

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D 358	Continued From page 22 64mg (used to treat muscle and nerve disorders) one tablet four times a day. Review of a clarification of medication physician's order for Resident #3's dated 03/31/21 revealed an order for Magnesium 64mg one tablet four times a day. Review of Resident #3's current FL-2 dated 04/07/21 revealed an order for Magnesium 64mg one tablet four times a day. Review of Resident #3's February 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Mag64 64mg take one tablet four times daily scheduled to be administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Mag64 64mg was documented as administered every day at 8:00am, 12:00pm, 4:00pm, and 8:00pm from 02/01/21-02/28/21. Review of Resident #3's March 2021 eMAR revealed: -There was an entry for Mag64 64mg take one tablet four times daily scheduled to be administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Mag64 64mg was documented as administered every day at 8:00am, 12:00pm, 4:00pm, and 8:00pm from 03/01/21-03/23/21 at 8:00am and 03/26/21-03/31/21. Review of Resident #3's April 2021 eMAR revealed: -There was an entry for Mag64 64mg take one tablet four times daily scheduled to be administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm.	D 358		

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-Mag64 64mg was documented as administered every day at 8:00am, 12:00pm, 4:00pm, and 8:00pm from 04/01/21-04/14/21 at 12:00pm.

Observation of the medication pass on 04/14/2021 at 12:25pm revealed the Resident Care Coordinator (RCC) administered Resident #3 Slow Mag Mg one tablet.

Observation of Resident #3's medications on hand on 04/15/21 at 3:45pm revealed:
-There was a bottle of SlowMag Mg tablets in the original manufacturer's container with no prescription labeling.
-The supplement information printed on the label included the serving size was 2 tablets, and ingredients per serving included magnesium 143mg, calcium 238mg, chloride 416mg.

Interview with the RCC on 04/15/21 at 3:50pm revealed:
-She administered medication to Resident #3.
-The over-the-counter supply of SlowMag Mg was the magnesium used to administer to Resident #3 and was supposed to be equivalent to Mag 64 64mg.
-The facility Owner picked up the SlowMag Mg for Resident #3. She would go to the over-the-counter (OTC) section in the local department store and pick up the SlowMag Mg.
-If the Owner had questions she could always go to the pharmacy for direction.

Interview with the facility Owner on 04/16/21 at 10:59am revealed:
-She picked up the SlowMag Mg from a local store in the section where over-the-counter medications were stored.
-She "asked girl or guy behind the counter and was told it was the same" magnesium Resident

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D 358	Continued From page 24 #3 was prescribed. -She expected the medication on hand to match the medication printed on the eMAR. -She expected the medication aides (MA) to notify someone if the medication on hand was not in the facility and contact the physician if a prescription was needed to reorder a medication the physician wanted the resident to be administered. Interview with the facility Administrator on 04/16/21 at 10:59am revealed: -He expected the medication on hand to match the medication printed on the eMAR. -He expected the MA to notify himself and the Owner if the medication on hand was not in the facility and contact the physician if a prescription was needed to reorder a medication the physician wanted the resident to be administered. Telephone interview the Resident #3's Primary Care Provider (PCP) on 04/16/21 at 12:07pm revealed: -He did not like the idea of Resident #3 being administered multiple different vitamins. -An excess of magnesium could cause diarrhea, weakness, nausea, and vomiting. -The facility should have called him about Resident #3's magnesium medication. -He would rather Resident #3 not be administered OTC medications. Telephone interview with the Pharmacist from the contracted pharmacy on 04/16/21 at 2:20pm revealed: -Resident #3 was being administered too much magnesium. -The body would usually get rid of magnesium. -An excess of magnesium intake could interfere with heart rhythm.	D 358		

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-The Pharmacists could assist with OTC medications if the pharmacy had a prescription.
-The Pharmacist could provide information on medication equivalencies, and the pharmacy did not have any control if a person came into the store and picked up the medication themself.

b. Review of Resident #3's physician's orders dated 12/12/20 revealed an order for Calcium (a dietary supplement) 500mg one tablet three times a day.

Review of a clarification of medication physician's order for Resident #3's dated 03/31/21 revealed an order for Calcium 500mg one tablet three times a day.

Review of Resident #3's current FL-2 dated 04/07/21 revealed an order for Calcium Carbonate 500mg one tablet three times a day.

Review of Resident #3's February 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Calcium 500mg take one tablet three times daily scheduled to be administered at 8:00am, 12:00pm, and 8:00pm.
-Calcium 500mg was documented as administered every day at 8:00am, 12:00pm, and 8:00pm from 02/01/21-02/28/21.

Review of Resident #3's March 2021 eMAR revealed:
-There was an entry for Calcium 500mg take one tablet three times daily scheduled to be administered at 8:00am, 12:00pm, and 8:00pm.
-Calcium 500mg was documented as administered every day at 8:00am, 12:00pm, and 8:00pm from 03/01/21-03/23/21 at 8:00am and 03/26/21-03/31/21.

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	HAL026048	A. BUILDING: _____ B. WING _____	R 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE VALLEY ADULT CARE HOME	3522 CAMDEN ROAD FAYETTEVILLE, NC 28306

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 26 Review of Resident #3's April 2021 eMAR revealed: -There was an entry for Calcium 500mg take one tablet three times daily scheduled to be administered at 8:00am, 12:00pm, and 8:00pm. -Calcium 500mg was documented as administered every day at 8:00am, 12:00pm, and 8:00pm from 04/01/21-04/14/21 at 12:00pm. Observation of Resident #3's medications on hand on 04/15/21 at 3:45pm revealed: -There was a bottle labeled Calcium, Magnesium, & Zinc plus Vitamin D3 tablets in the original manufacturer's container with no prescription labeling. -The supplement information printed on the label included the serving size was 3 tablets, and ingredients per serving included vitamin D3 15mcg, calcium 1000mg, magnesium 400mg, and zinc 15mg. Observation of the medication pass on 04/14/2021 at 12:25pm revealed the Resident Care Coordinator (RCC) administered Resident #3 Calcium, Magnesium, & Zinc OTC one tablet. Interview with the RCC on 04/15/21 at 3:50pm revealed: -She administered medication to Resident #3. -The over-the-counter (OTC) supply of Calcium, Magnesium, & Zinc plus Vitamin D3 tablets was the medication used to administer to Resident #3 for the Calcium 500mg that was prescribed by the Primary Care Provider (PCP). -The facility Owner picked up the Calcium, Magnesium, & Zinc plus Vitamin D3 tablets for Resident #3. She went to the OTC section in the local department store and picked up the Calcium, Magnesium, & Zinc plus Vitamin D3	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 27 tablets. -The Calcium, Magnesium, & Zinc plus Vitamin D3 tablets on hand did not match Calcium 500mg that was prescribed by the PCP for Resident #3. -If the Owner had questions she could always go to the pharmacy for direction. Interview with the facility Owner on 04/16/21 at 10:50am revealed: -She picked up the Calcium, Magnesium, & Zinc plus Vitamin D3 tablets from a local store in the section where over-the-counter medications were stored. -She thought she had picked up Calcium 250mg mg tablets, but could now see the 250 printed on the Calcium, Magnesium, & Zinc plus Vitamin D3 tablets labeled bottle was the count of pills in the container. -She "asked girl or guy behind the counter and was told it was the same" magnesium Resident #3 was prescribed. -She expected the medication on hand to match the medication transcribed to the eMAR. -She expected the medication aides (MA) to notify someone if the medication on hand was not in the facility and contact the physician if a prescription was needed to reorder a medication the physician wanted the resident to be administered. Interview with the facility Administrator on 04/16/21 at 10:50am revealed: -He expected the medication on hand to match the medication transcribed to the eMAR. -He expected the MAs to notify himself and the Owner if the medication on hand was not in the facility, and contact the physician if a prescription was needed to reorder a medication the physician wanted the resident to be administered.	D 358		

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D 358	Continued From page 28 Telephone interview the Resident #3's physician on 04/16/21 at 12:07pm revealed: -He did not like the idea of Resident #3 being administered multiple different vitamins. -He discontinued the Calcium today (04/16/21). -An excess of vitamin D and magnesium could cause diarrhea, weakness, and nausea and vomiting. -The facility should have called him about Resident #3's medication. -He would rather Resident #3 not be administered OTC medications. -He did not have any "major concerns" with regards to the dose Resident #3 was getting. Telephone interview with the Pharmacist from the contracted pharmacy on 04/16/21 at 2:20pm revealed: -The pharmacy profile for Resident #3 did not include the order for Calcium. -The facility might be getting the Calcium from the OTC section of the department store. -The Calcium, Magnesium, & Zinc plus Vitamin D3 was not "plain calcium". -The resident might experience some constipation if getting too much calcium. -Resident #3 was being administered too much magnesium. -The body would usually get rid of magnesium. -An excess of magnesium intake could interfere with heart rhythm. -The Pharmacists could assist with OTC medications if the pharmacy had a prescription. --The Pharmacist could provide information on medication equivalencies, and the pharmacy did not have any control if a person came into the store and picked up the medication themself. Based on observations, record reviews, and interviews, it was determined Resident #3 was	D 358		

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D 358	Continued From page 29 not interviewable. _____ The facility failed to administer medications as ordered for 2 of 11 residents observed during the medication pass resulting in an 8% medication error rate with 2 errors out of 25 opportunities including Resident #2, who had a diagnosis of arthritis and had not received a full dose of medication which could result in increased pain, and Resident #3 who had a diagnosis of Parkinson's disease and was not administered Pramipexole to control her tremors due to facility not ensuring medication was refilled and available for administration, which could result in uncontrollable tremors. Resident #2 was ordered Levemir insulin and was not administered 5 doses and Resident #4's Carbamazepine was documented as not administered 9 out of 31 opportunities in April 2021 which could result in seizure activity. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/16/21 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 31, 2021.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 30 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 11 residents (#2 #3) observed during the medication passes including errors with an anti-inflammatory and pain medication (#2) and not having a dopamine agonist medication refilled and available for administration (#3); and for 3 of 4 residents sampled (#2,#3.#4) for record review including errors with medications to treat diabetes (#2), dietary supplements (#3), and not administering numerous doses of an anticonvulsant and an electrolyte medication (#4). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		